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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

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SUBJECT: Implementation Update #80
Update on Unmanaged Visits for Children
Service Orders for MH/SA TCM
VO ProviderConnect Reminders
Level III/IV Independent Psych. Evaluations
Accreditation of TCM Services
MH/SA TCM Providers & NC-TOPPS
NC-IRIS Update
Self-Direction for CAP-MR/DD Supports Waiver

Update on Unmanaged Visits for Children: Outpatient Behavioral Health Therapy Providers

As a result of action by the General Assembly, the 26 unmanaged outpatient behavioral health therapy visits limit for children will decrease to 16 unmanaged visits. Prior authorization will be required for all outpatient services **for children** after the 16th visit. **As a reminder, prior authorization will continue to be required for adults after the 8th visit.** To ease the transition for providers and recipients, this change will now be effective January 1, 2011, to correspond with the new benefit year.

Service Orders for Mental Health/Substance Abuse Targeted Case Management

As detailed in Implementation Update #77, there are currently two ways to request prior authorization for mental health/substance abuse (MH/SA) Targeted Case Management (TCM) services depending on the status of the authorization. Existing authorizations for MH/SA TCM recipients currently receiving the case management component of Community Support (CS) services may be transferred from a CS authorization to a MH/SA TCM authorization when a valid Critical Access Behavioral Health Agency (CABHA) submits a Letter of Attestation

to ValueOptions stating that TCM is clinically appropriate and that the person meets eligibility for the service. CABHA providers do not need to submit a person centered plan (PCP) or inpatient treatment report (ITR) when submitting a Letter of Attestation for the transfer of an existing authorization. In these instances, the current service order for the case management component of CS will be honored as the service order for MH/SA TCM. This service order will remain valid until the next concurrent request for MH/SA TCM.

A new service order, updated PCP and ITR, specific to TCM, is required when the provider submits the next concurrent request. The updated PCP must include goals related to MH/SA TCM.

For those recipients who have completed the full authorization period of the case management component of CS and have not used the MH/SA TCM attestation process, or for those recipients new to case management (who have never had case management via CS), any request for MH/SA TCM will be considered an initial authorization request for a new service. In these instances, an updated PCP with goals related to MH/SA TCM including a new signed service order for MH/SA TCM and an ITR must be submitted to the appropriate utilization review (UR) vendor (ValueOptions, The Durham Center, or Eastpointe) for this initial authorization request.

For State-funded consumers the provider shall follow the local management entity (LME) benefit plan and authorization process.

ValueOptions ProviderConnect Reminders

As a reminder, providers must register their Medicaid Provider Number (MPN) on ProviderConnect in order submit authorization requests electronically, view authorizations, and retrieve authorization letters online.

Providers interested in submitting enhanced, residential, mental health /substance abuse (MH/SA) and intellectual/developmental disabilities (I/DD) Targeted Case Management (TCM), and outpatient requests via ProviderConnect are encouraged to participate in regularly scheduled webinar training. To register for an upcoming session, go to http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll to the section titled *Provider Training Opportunities*. Click on the date you wish to attend and complete the registration form. The website is routinely updated with additional webinar dates.

Community Support Team, I/DD Targeted Case Management, and MH/SA Targeted Case Management

For Community Support Team (CST) providers that now have a new alpha suffix (V) appended to their MPN, direct enrolled providers of I/DD TCM, and CABHA organizations who have received their MPN for MH/SA TCM: it is important to note that those new MPNs for CST, I/DD TCM, and MH/SA TCM must be registered on ProviderConnect in order to submit authorization requests, view authorizations, and retrieve authorizations online.

Outpatient Authorizations

Outpatient authorizations have been entered to the attending MPN since July 1, 2010. Providers must search under the Attending MPN to retrieve authorization letters online.

Per Implementation Update #77, providers may submit outpatient requests with up to three MPNs on the ORF2 to allow for "reserve therapists" to receive authorization in addition to the primary attending therapist. Such requests may also be submitted online via ProviderConnect. The Attending MPNs (up to three) seeking authorization should be entered into the "Attending Provider Medicaid #" field separated by commas with no spaces. All Attending MPNs listed will be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary.

Contact the EDI/ProviderConnect Help Desk M-F 8am-6pm at 888-247-9311 for questions about creating or modifying an existing ProviderConnect account.

Independent Psychiatric Evaluation for Children Currently in Level III and Level IV

For children admitted to Residential Level III and IV services, length of stay is limited to no more than 120 days. If providers are submitting concurrent (reauthorization) requests for additional treatment after these 120 days, the provider must follow the authorization requirements for concurrent (reauthorization) requests as

outlined in Implementation Update #60 which includes an independent psychiatric evaluation, updated Child and Family Team meeting, and updated Discharge/Transition Plan signed and dated by the System of Care (SOC) coordinator. Please see full requirements in Implementation Update #60.

This is a reminder that children currently in Level III and Level IV residential treatment must have an independent (meaning independent of the residential provider and its provider organization) psychiatric evaluation as one of the requirements for concurrent (reauthorization) requests. The psychiatric evaluation must be performed by a psychiatrist, psychiatric physician's assistant (PA) who is working under a psychiatrist's protocol or an Advanced Practice Nurse Practitioner (APN) only. The psychiatric evaluation shall determine the clinical needs of the child and make recommendations for the appropriate level of treatment such as residential, Psychiatric Residential Treatment Facilities (PRTF), or other level of care.

Required components of the psychiatric evaluation can be found in Implementation Update #36 under "Comprehensive Clinical Assessment." All components of the Comprehensive Clinical Assessment must be included in this first concurrent (reauthorization) request for Level III and Level IV.

In some instances, providers are requesting additional concurrent authorizations (beyond the first concurrent request). In these instances, an updated psychiatric evaluation is required. For these additional concurrent requests, if the same psychiatrist, PA, or APN that completed the original psychiatric evaluation does the psychiatric evaluation and it is an actual update to a previous complete evaluation and report, then a shorter updated evaluation and report may be provided with the concurrent authorization request. That evaluation and report should include at a minimum the following elements:

1. an update of the presenting problems that brought the child into treatment as well as progress on presenting problems and current risk factors, including interview informant participation;
2. a current mental status including engagement of recipient in treatment and a listing of current medications;
3. an assessment of progress in school, with peers, and with family including involvement of family in treatment and progress of recipient toward discharge;
4. evidence of consumer/legally responsible person's participation in the assessment;
5. recommendation regarding target population eligibility (state-funded services only);
6. an updated analysis and interpretation of the assessment information with an appropriate case formulation;
7. diagnoses on all five (5) axes of DSM-IV with any changes noted;
8. name of the facility where the Child and Family Team is planning to place the child/adolescent; and
9. recommendations for additional assessments, services, support, or treatment based on the results of the comprehensive clinical assessment, to include an indication of whether or not treatment is meeting recipient's needs, notation of any concerns about the treatment setting, and an assessment of how much longer services are indicated as well as recommendations for treatment and alternatives.

All requests that are not accompanied by the psychiatric assessment will be returned as, "Unable to Process."

Level III and Level IV providers should be collaborating with the LME and SOC coordinator throughout this process.

Discharge/Transition Plans for Level III and Level IV Residential Services
Discharge/Transition Plans for children in Level III and Level IV Residential services must accompany all requests for authorization for these services submitted to ValueOptions, Durham, or Eastpointe, depending on the catchment area of the recipient. All signatures and dates on the Discharge/Transition Plan must be hand written. The Discharge/Transition Plan may be faxed or scanned for submission to ValueOptions, Durham, or Eastpointe, depending on the catchment area of the recipient. The Discharge/Transition Plan must include the signature of an authorized representative of the LME/SOC coordinator to be considered valid and to be processed Discharge/Transition Plans must be revised, signed and dated every 90 days.

Accreditation of the Targeted Case Management Service

Targeted Case Management for individuals with mental health and substance use disorders, as well as Targeted Case Management for persons with intellectual/developmental disabilities, is a new standalone service with the requirement for the agency providing the service to acquire national accreditation.

For those CABHA agencies which choose to provide TCM for MH/SA consumers, and those agencies which choose to provide TCM for persons with I/DD, the same requirements which are in place for other services apply to these services.

That means that if the agency has already achieved national accreditation, then, per Implementation Update #53 (February 3, 2009), that agency is not required to have the TCM service accredited until the accrediting agency for the provider schedules and performs the next regular review of the agency. However, if the agency has not been previously accredited, the agency is then subject to the guidance in GS.122C-81, "National accreditation Benchmarks." Those benchmarks specify that the agency must be accredited within one year, and that the interim benchmarks identified in the statute must be met. Failure to meet any of those interim benchmarks, in addition to failure to meet the one-year requirement for accreditation, will result in the withdrawal by the LME of the endorsement to provide the service.

For the purpose of identification of the specific timelines for each agency, the required year begins with the enrollment by the Division of Medical Assistance (DMA) of the provider for the provision of the service.

MH/SA TCM Providers to Participate in NC - Treatment Outcomes and Program Performance System

Effective immediately, all providers of MH/SA TCM are required to participate in the NC-Treatment Outcomes and Program Performance System (NC-TOPPS), as MH/SA TCM is an outcome-focused service. Responsibility for completing NC-TOPPS interviews lies with the consumer's *primary provider agency*. This is the provider agency that provides a qualifying mental health and/or substance abuse service to the consumer and is providing case management functions for the consumer (including the consumer's PCP/treatment plan. The revised NC-TOPPS Service Codes Criteria can be found in Appendix A of the *SFY 2010-11 NC-TOPPS Implementation Guidelines* and is published on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) web page:
http://www.ncdhhs.gov/mhddsas/nc-topps/systemuser/nc-toppsguidelinesoctober10.pdf

NC-Incident Response Improvement System Update

Changes to the Incident Response Improvement System (IRIS) were implemented on September 23, 2010 to address reporting issues identified by providers. Details of these changes can be found in an updated version of "IRIS Frequently Asked Questions" at http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/iris-faq-condensed.pdf, including:

- Downloading IRIS data to provider IT systems
- Changes to required fields
- Expanded directions and "Help" information
- Schedule for future system changes

Update on Self-Direction for CAP-MR/DD Supports Waiver Participants

DMH/DD/SAS in partnership with DMA has been working on finalizing the required operational details to implement Self-Direction in the CAP-MR/DD Supports Waiver. With this model of Self-Direction there are two required functions, the Financial Management Services Agency and the Support Broker. The Support Broker function is called the Community Resource Consultant. The DMH/DD/SAS has selected, through a RFA process, two vendors to provide the services of Community Resource Consultant (CRC).

The two vendors selected to provide the CRC services are: 1) The Arc of North Carolina and, 2) Central State of the Carolinas. Both vendors have many years of experience providing services and supports to individuals who receive CAP-MR/DD funding. Through the application process both agencies demonstrated the knowledge and ability to be successful in the role of CRC.

The role of the CRC is to assist the participant in self-directing their services and supports. The CRC trains, advises, and assists the participant in hiring, training, scheduling, and managing their staff. Some of the

responsibilities of the CRC are to assist the participant in identifying natural and community supports, and to guide the participant regarding their budgetary responsibilities.

Also, in collaboration with DMA a RFP process was conducted to select a vendor to perform the functions of a Financial Management Service (FMS). In Self-Direction, the FMS agency serves as the employer of record for the individual staff selected by the participant; administers payroll, taxes, and insurance for staff selected by the participant; and exercises budget authority for the participant. The vendor selected as the FMS is G.T. Financial Services.

GT Financial Services is owned and operated by individuals who have years of experience as financial administrators and have been operating as a family business providing fiscal *INTERMEDIARY* services for individuals participating in self-direction in Wisconsin and Michigan.

Currently the DMH/DD/SAS is working with the two CRC vendors (The Arc of North Carolina and Central State of the Carolinas), the FMS vendor (G.T. Financial Services, the LMEs, CAP-MR/DD Supports Waiver participants, and the DMA to implement Self-Direction for CAP-MR/DD Supports Waiver participants. Efforts have begun to inform eligible individuals of the Self-Direction option. More information about the implementation of Self-Direction will be provided in future Implementation Updates.

Information about Self-Direction in the CAP-MR/DD Supports Waiver can be found on the DMH/DD/SAS website at: http://www.ncdhhs.gov/mhddsas/selfdirect/index.htm.

As indicated in Implementation Update # 76 (July 7, 2010) *Implementation Plan for the CAP-MR/DD Clinical Policy, CAP MR/DD Comprehensive Waiver and Supports Waiver Manuals and Technical Amendment Number One,* the following describes the process regarding exception and/or extension requests related to the implementation of the required policy changes. The *CAP-MR/DD Policy Requirement Extension/Exception Request Form* is the required form for making an exception/extension request.

The form can be found at: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm

The new policies contained in Implementation Update #76 (inclusive of the Clinical Policy) will be effective February 1, 2011 unless otherwise noted. Participants, guardians and legally responsible persons will have this time to determine alternate support options to ensure the health and safety needs are adequately addressed.

In the event a participant can not make the transition to the policy changes **by the February 1, 2011 effective date**, the DMH/DD/SAS will review the participant's PCP and determine if further time is needed or if other actions are necessary for the participant to safely make the transition

The process to request an exception and/or extension for individuals who are unable to make the needed changes as required by February 1, 2011 is as follows:

- **By December 1, 2010 the case manager must send the LME the request for an extension or exception using the *CAP-MR/DD Policy Requirements Extension/Exception Request Form.*** The request shall contain the revised PCP with any/all documentation and justification as to the specific health and safety issues and reasons why the individual can not meet the transition requirements
- The LME will review the request for an extension or exception, including the revised PCP and discuss with the case manager the specific health and safety issues preventing transition as required by February 1, 2011 and possible alternatives to address the individual's support needs.
- By January 1, 2011 the LME shall send the completed ***CAP-MR/DD Policy Requirements Extension/Exception Request Form*** and PCP with accompanying documentation/justification to the DMH/DD/SAS designated PCP review staff and request an extension or exception to the required transition. The LME shall use **secure FAX number: 919-508-0967.**
- The DMH/DD/SAS designated PCP review staff will review the completed ***CAP-MR/DD Policy Requirements Extension/Exception Request Form***, the PCP and accompanying documentation/justification and discuss with the LME and case manager if appropriate.

- If the DMH/DD/SAS designated PCP review staff determine the individual has health and safety risks that may be affected by the required transition an extension or exception may be granted.
- An extension or exception may be granted **ONLY if the services are necessary to assure the health and safety of the participant.**
  - If services are requested to assure the health and safety of the participant, the PCP must clearly describe:
    - how the health and safety of the participant is at risk without these services, **AND**
    - measures taken to use natural and other community supports to assure the health and safety of the individual, **AND**
    - demonstrate that no other options are available to assure health and safety of the participant other than providing services that will exceed the UR guidelines.
- Within 15 days from receipt the DMH/DD/SAS designated PCP review staff will provide a written response to the LME indicating the decision for the extension or exception request.
- If the DMH/DD/SAS approves the request, notification will be provided to the LME who will in turn notify the case manager.
- If the DMH/DD/SAS determines an extension or exception is not justified and denies the request, the DMH/DD/SAS will notify the participant and guardian (copying the LME). The LME will notify the case manager.
- **Participants have due process rights as follows**: Persons whose requests for waiver services are denied, reduced, terminated or suspended; denied the provider of their choice; or, denied level of care (LOC) are issued a written notice that states the adverse action, citation supporting the action, and due process of appeal rights for a fair hearing or formal appeal conducted by the Office of Administrative Hearings (OAH). If a consumer is not receiving services, OAH will expedite the hearing request. This notice must be mailed at least **10 days** prior to the effective date of the adverse action. If the recipient chooses to appeal the decision, he/she has **30 days** from the date the notice is mailed to appeal the decision. Should the recipient appeal within the mandated timeframe and should the recipient currently receive services, those services continue for the pendency of the appeal. N.C.G.S. 150B-31.2(c) allows each recipient to be offered mediation prior to a fair hearing. This mediation takes place outside of OAH. If the mediation successfully resolves the case to the recipient's satisfaction, the case is dismissed. Should the recipient reject the offer of mediation or the mediation is unsuccessful, the case proceeds to fair hearing.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

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